

<i>SERFF Tracking Number:</i>	<i>GHPI-126163116</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Coventry Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42478</i>
<i>Company Tracking Number:</i>	<i>ARRAQ09</i>		
<i>TOI:</i>	<i>H15G Group Health - Hospital/Surgical/Medical Sub-TOI:</i>		<i>H15G.001 Any Size Group</i>
	<i>Expense</i>		
<i>Product Name:</i>	<i>AR RAQ 09</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: AR RAQ 09

SERFF Tr Num: GHPI-126163116 State: ArkansasLH

TOI: H15G Group Health -

SERFF Status: Closed

State Tr Num: 42478

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.001 Any Size Group

Co Tr Num: ARRAQ09

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Anita Carter, Geneva Clark

Disposition Date: 05/29/2009

Date Submitted: 05/22/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/29/2009

Explanation for Other Group Market Type:

State Status Changed: 05/29/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

(314) 506-1928

acarter@cvty.com

May 22, 2009

SERFF Tracking Number: GHPI-126163116 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 42478  
Company Tracking Number: ARRAQ09  
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group  
Expense  
Product Name: AR RAQ 09  
Project Name/Number: /

Rosalind Minor  
Sr. Certified Rate & Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, Arkansas 72201

Re: Co Tracking #: ARRAQ09  
Form #: CHAR 00006 (4-09)  
Employer Risk Assessment Questionnaire (RAQ)

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced document.

The intended market for this document is the employer group market. This document is a replacement document. This document will be issued to employers.

In addition, please note the following:

1. A check in the amount of \$20.00 will be sent under separate cover as per our email discussion on September 25, 2008 for this filing.
2. In compliance with Rule & Regulation 19, this document does not discriminate on the basis of sex.
3. In compliance with Rule & Regulation 49, an Insurance Guaranty Association Notice will be sent under separate cover.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

<i>SERFF Tracking Number:</i>	<i>GHPI-126163116</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Coventry Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42478</i>
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<i>TOI:</i>	<i>H15G Group Health - Hospital/Surgical/Medical Sub-TOI:</i>		<i>H15G.001 Any Size Group</i>
	<i>Expense</i>		
<i>Product Name:</i>	<i>AR RAQ 09</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Anita J. Carter, RN  
 Manager, Regulatory Compliance

## Company and Contact

### Filing Contact Information

Anita Carter, Manager of Regulatory Compliance	acarter@cvty.com
550 Maryville Centre Drive	(314) 506-1928 [Phone]
St. Louis, MO 63141-5818	(314) 506-1672[FAX]

### Filing Company Information

Coventry Health and Life Insurance Company	CoCode: 81973	State of Domicile: Delaware
6705 Rockledge Drive	Group Code: 1137	Company Type:
Suite 900		
Bethesda, MD 20817	Group Name:	State ID Number:
(314) 506-1700 ext. [Phone]	FEIN Number: 75-1296086	
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## Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number: GHPI-126163116 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 42478  
Company Tracking Number: ARRAQ09  
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group  
Expense  
Product Name: AR RAQ 09  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/29/2009	05/29/2009

SERFF Tracking Number:	GHPI-126163116	State:	Arkansas
Filing Company:	Coventry Health and Life Insurance Company	State Tracking Number:	42478
Company Tracking Number:	ARRAQ09		
TOI:	H15G Group Health - Hospital/Surgical/Medical Sub-TOI:		H15G.001 Any Size Group
	Expense		
Product Name:	AR RAQ 09		
Project Name/Number:	/		

## Disposition

Disposition Date: 05/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GHPI-126163116 State: Arkansas  
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 42478  
 Company Tracking Number: ARRAQ09  
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group  
 Expense  
 Product Name: AR RAQ 09  
 Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Previously approved RAQ form	Approved-Closed	Yes
Form	Employer Risk Appraisal Questionnaire	Approved-Closed	Yes

SERFF Tracking Number: GHPI-126163116 State: Arkansas

Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 42478

Company Tracking Number: ARRAQ09

TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group  
Expense

Product Name: AR RAQ 09

Project Name/Number: /

## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	CHAR	Application/	Employer Risk	Initial			CHAR 00006
Closed	00006 (4-09)	Enrollment Form	Appraisal Questionnaire				(4-09).pdf



**Employer Risk  
 Appraisal Questionnaire  
 Groups 51+ Enrolled Employees**

This questionnaire is designed to provide information specific to your group and will be used in evaluating the risk characteristics to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.

<b>I. GENERAL INFORMATION</b>						
Company Name						
Company Address/City/State/Zip						
Phone Number				Requested Effective Date		
Nature of Business & SIC				Years in Operation		
Reason Out to Bid						
Please list any employer locations other than noted above.						
<b>II. GROUP ELIGIBILITY</b>						
Total Employees			Total Eligible for Coverage			
Part Time	Full-time	Retiree	COBRA			
Spousal Waivers	CHAMPUS Waivers	Other Waivers	<b>Total Waivers</b>			
<p><b><i>Please see your Coventry rate proposal for complete eligibility and quoting policies.</i></b>          Please provide a listing of employees and/or dependants that meet the following criteria. Please sign and date all attachments.</p> <ul style="list-style-type: none"> <li>COBRA: former employees and/or dependents covered or eligible to receive coverage under state or COBRA continuation. Please list employees' termination date.</li> <li>Retirees: if eligible for coverage with Coventry</li> <li>Out-of-Area employees/members applying for coverage with Coventry.</li> </ul>						
Employer Contribution:	Employee	Dependent				
Waiting Period						
Are all eligible employees covered by Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If no, please explain:						
<b>III. COVERAGE INFORMATION (List all health carriers in the last five years)</b>						
Carrier		Effective Date	Types of Coverage		Reason for Change	
RATES	Employee	EE/Child	EE/Spouse	EE/Children	Family	Plan Description*
Current	\$	\$	\$	\$	\$	\$
Renewal	\$	\$	\$	\$	\$	\$
<p><b>*Please attach</b> a current benefit booklet, previous benefits, and plan changes for the most recent 2-year period.</p> <p>Previously covered by Coventry? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please provide the time covered: _____ through _____.</p>						

#### IV. HEALTH INFORMATION

Provide the answers to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs, and eligible retirees). Coventry reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate, incomplete or misrepresented. **For each item marked "YES" below, please provide an explanation in Section F on the next page. If additional space is required, please attach a separate sheet that has been signed and dated.**

**A.** To your knowledge has any person (employee and/or employee's dependents, or *COBRA individuals*) to be covered had any of the following conditions within the last 36 months? (Please check Yes or No. If yes, please circle all conditions that apply.)

- |   |                              |                             |                    |
|---|------------------------------|-----------------------------|--------------------|
| 1. Alcohol or substance abuse   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 2. Rheumatoid/Osteoarthritis, lupus, scleroderma                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 3. Asthma, emphysema, cystic fibrosis, or other lung disease                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 4. Diabetes: Type (if known) _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 5. Cancer or other tumors   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 6. Epilepsy/seizure disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 7. Disorder of the spine, back, joints, bones                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 8. Blood disorders, sickle cell   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 9. Peripheral vascular disease, high blood pressure, cholesterol                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 10. Heart disease or angina   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 11. Stroke, paralysis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 12. Kidney or bladder disease, kidney dialysis                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 13. Liver disease or hepatitis: Type (if known) _____                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 14. Multiple sclerosis, muscular dystrophy, or cerebral palsy                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 15. Psychological or other mental disorder                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 16. Organ transplant (planned or past)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 17. HIV/AIDS or any autoimmune disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 18. Tuberculosis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 19. Stomach ulcers, colitis, or Crohn's disease                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 20. Any condition or disease not mentioned above, or <i>anticipated surgery</i> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |

**B.** Have any employees, dependents, or COBRA individuals who are eligible for coverage suffered from a condition that resulted in a claim of \$5,000 or more (medical and/or pharmacy) during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No # of people: \_\_\_\_\_

**C.** Have any employees requested Medical Family Leave or short-term disability within the past 30 days? (Please give details if known medical reason.) ☐ Yes ☐ No # of people: \_\_\_\_\_

**D.** Are any employees currently disabled or otherwise not actively-at-work? (Give medical details and date disability started.) ☐ Yes ☐ No # of people: \_\_\_\_\_

**E.** Are any eligible employees or dependents currently pregnant? ☐ Yes ☐ No # of people: \_\_\_\_\_  
Ages \_\_\_\_\_  
Due Dates \_\_\_\_\_

Does the pregnant individual have a history of complications (including cesarean section)? ☐ Yes ☐ No # of people: \_\_\_\_\_

Is the pregnant individual aware of, or been advised of, any complications with the current pregnancy? ☐ Yes ☐ No # of people: \_\_\_\_\_

**F. Please explain all "YES" answers in this section. Please indicate what question you are answering.  
If additional space is required, please attach a separate sheet that has been signed and dated.**

Response to Question	Emp/ Dep	Age	Diagnosis/Condition	Treatment (include dates of onset and recovery)	Medications	Claim Amounts

## V. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in this Employer Risk Appraisal Questionnaire is complete and accurate to the best of my knowledge. It is further understood that Coventry reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate, incomplete or misrepresented. I understand that Coventry may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that Coventry may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify Coventry for any liability damages resulting from any misrepresentation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by the employer. It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_  
(Company executive or senior Human Resources employee)  
Date \_\_\_\_\_

*SERFF Tracking Number:*      *GHPI-126163116*                      *State:*                      *Arkansas*

*Filing Company:*              *Coventry Health and Life Insurance Company*      *State Tracking Number:*              *42478*

*Company Tracking Number:*      *ARRAQ09*

*TOI:*                      *H15G Group Health - Hospital/Surgical/Medical Sub-TOI:*                      *H15G.001 Any Size Group*

*Expense*

*Product Name:*              *AR RAQ 09*

*Project Name/Number:*              */*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: GHPI-126163116 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 42478  
Company Tracking Number: ARRAQ09  
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group  
Expense  
Product Name: AR RAQ 09  
Project Name/Number: /

## Supporting Document Schedules

**Review Status:**  
**Bypassed -Name:** Flesch Certification Approved-Closed 05/29/2009  
**Bypass Reason:** N/A This form is not to be completed by members/applicants.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Application Approved-Closed 05/29/2009  
**Bypass Reason:** N/A This is not a policy form.  
**Comments:**

**Review Status:**  
**Satisfied -Name:** Previously approved RAQ form Approved-Closed 05/29/2009  
**Comments:**

Attached is the previously approved RAQ. Please note the following changes to this form. No other changes have been made.

- 1) The statement "For each item marked "YES" below, please provide an explanation in Section F on the next page. If additional space is required, please attach a separate sheet that has been signed and dated." has been moved from the middle of the page to the introductory statement in Section IV "Health Information".
- 2) The phrase "even if unintentional" has been deleted from the second sentence in Section V "Statement of Understanding".

**Attachment:**  
CHAR 00006\_DOI Approved 021108.pdf

**Employer Risk  
Appraisal Questionnaire**  
**Groups 51+ Enrolled Employees**

This questionnaire is designed to provide information specific to your group and will be used in evaluating the risk characteristics to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.

**I. GENERAL INFORMATION**

Company Name	
Company Address/City/State/Zip	
Phone Number	Requested Effective Date
Nature of Business & SIC	Years in Operation
Reason Out to Bid	
Please list any employer locations other than noted above.	

**II. GROUP ELIGIBILITY**

Total Employees		Total Eligible for Coverage	
Part Time	Full-time	Retiree	COBRA
Spousal Waivers	CHAMPUS Waivers	Other Waivers	<b>Total Waivers</b>

**Please see your Coventry rate proposal for complete eligibility and quoting policies.**

Please provide a listing of employees and/or dependants that meet the following criteria. Please sign and date all attachments.

- COBRA: former employees and/or dependents covered or eligible to receive coverage under state or COBRA continuation. Please list employees' termination date.
- Retirees: if eligible for coverage with Coventry
- Out-of-Area employees/members applying for coverage with Coventry.

Employer Contribution:	Employee	Dependent
Waiting Period		
Are all eligible employees covered by Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, please explain:		

**III. COVERAGE INFORMATION (List all health carriers in the last five years)**

Carrier	Effective Date	Types of Coverage			Reason for Change	
RATES	Employee	EE/Child	EE/Spouse	EE/Children	Family	Plan Description*
Current	\$	\$	\$	\$	\$	\$
Renewal	\$	\$	\$	\$	\$	\$

**\*Please attach** a current benefit booklet, previous benefits, and plan changes for the most recent 2-year period.

Previously covered by Coventry? ☐ Yes ☐ No  
If yes, please provide the time covered: \_\_\_\_\_ through \_\_\_\_\_.

#### IV. HEALTH INFORMATION

Provide the answers to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs, and eligible retirees). Coventry reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate or incomplete.

**A.** To your knowledge has any person (employee and/or employee's dependents, or *COBRA individuals*) to be covered had any of the following conditions within the last 36 months? (Please check Yes or No. If yes, please circle all conditions that apply.)

- |   |                              |                             |                    |
|---|------------------------------|-----------------------------|--------------------|
| 1. Alcohol or substance abuse   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 2. Rheumatoid/Osteoarthritis, lupus, scleroderma                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 3. Asthma, emphysema, cystic fibrosis, or other lung disease                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 4. Diabetes: Type (if known) _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 5. Cancer or other tumors   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 6. Epilepsy/seizure disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 7. Disorder of the spine, back, joints, bones                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 8. Blood disorders, sickle cell   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 9. Peripheral vascular disease, high blood pressure, cholesterol                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
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| 12. Kidney or bladder disease, kidney dialysis                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
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| 16. Organ transplant (planned or past)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
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| 19. Stomach ulcers, colitis, or Crohn's disease                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 20. Any condition or disease not mentioned above, or <i>anticipated surgery</i> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |

**For each item marked "YES" below, please provide an explanation in Section F on the next page. If additional space is required, please attach a separate sheet that has been signed and dated.**

**B.** Have any employees, dependents, or COBRA individuals who are eligible for coverage suffered from a condition that resulted in a claim of \$5,000 or more (medical and/or pharmacy) during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No # of people: \_\_\_\_\_

**C.** Have any employees requested Medical Family Leave or short-term disability within the past 30 days? (Please give details if known medical reason.) ☐ Yes ☐ No # of people: \_\_\_\_\_

**D.** Are any employees currently disabled or otherwise not actively-at-work? (Give medical details and date disability started.) ☐ Yes ☐ No # of people: \_\_\_\_\_

**E.** Are any eligible employees or dependents currently pregnant? ☐ Yes ☐ No # of people: \_\_\_\_\_  
Ages \_\_\_\_\_  
Due Dates \_\_\_\_\_

Does the pregnant individual have a history of complications (including cesarean section)? ☐ Yes ☐ No # of people: \_\_\_\_\_

Is the pregnant individual aware of, or been advised of, any complications with the current pregnancy? ☐ Yes ☐ No # of people: \_\_\_\_\_

**F. Please explain all "YES" answers in this section. Please indicate what question you are answering.  
If additional space is required, please attach a separate sheet that has been signed and dated.**

Response to Question	Emp/ Dep	Age	Diagnosis/Condition	Treatment (include dates of onset and recovery)	Medications	Claim Amounts

## V. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in this Employer Risk Appraisal Questionnaire is complete and accurate to the best of my knowledge. It is further understood that Coventry reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate or incomplete, even if unintentional. I understand that Coventry may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that Coventry may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify Coventry for any liability damages resulting from any misrepresentation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by the employer. It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_  
(Company executive or senior Human Resources employee)  
Date \_\_\_\_\_